

**Texas Department of Insurance, Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**PART I: GENERAL INFORMATION**

Requestor's Name and Address:	MFDR Tracking #:	M4-09-B130-01
	DWC Claim #:	
	Injured Employee:	
	Date of Injury:	
Respondent Name and Box #: TASB RISK MGMT FUND REP. BOX #: 47	Employer Name:	
	Insurance Carrier #:	

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary was not submitted by the Claimant.

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "After receiving the prescription stub on 6/1/09, Christina Aleman, Assistant Manager, called [claimant] and asked her for a copy of a cancelled check, a credit card charge statement or statement from the pharmacy that she had paid for the drug. She asked her to fax or mail one of those forms of proof of payment. To date, we have not received any documentation."

PART IV: SUMMARY OF FINDINGS

Eligible Dates of Service (DOS)	CPT Codes and Calculations	Part V Reference	Amount Ordered
N/A	Out-of-pocket expenses for Prescription Medications	1 – 4	N/A

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

1. The Claimant submitted form LHL-009 requesting an Independent Review Organization (IRO) review for prescription medications.
2. The claimant was contacted; during the course of the conversation it was discovered that she had paid out-of-pocket expenses for prescription medications. According to the injured worker, she was given Form LHL-009 by her local DWC Field Office and told to submit the form to DWC-Medical Fee Dispute Resolution (MFDR). It was explained to the injured worker this was not the proper form to submit to MFDR and she would need to send the receipt to the insurance carrier. The claimant was also informed that per Division Rule at 28 TAC 134.504(a)(2) the carrier has 45 days to reimburse her or should the carrier deny the payment they shall include a full and complete explanation of the reason(s) the insurance carrier reduced or denied the payment and shall inform the injured employee of her right to request medical dispute resolution in accordance with Division Rule 133.305.
3. In accordance with Division Rule at 28 TAC 133.307(4), "the Division will forward a copy of the request and the documentation submitted in accordance with paragraph (2) or (3) of this subsection to the respondent." Lucy Hopkins of Texas Association of School Boards Risk Management Fund (TASB) was faxed the LHL009 on August 19, 2009 to comply with this rule. TASB Risk Management responded via E-mail on August 19, 2009. The Respondent also submitted a copy of a letter, dated May 28, 2009, mailed to the claimant explaining that an Independent Review Organization (IRO) was for the purpose of reviewing medical necessity of treatment to the compensable injury; they also requested documentation or evidence to support the amount the claimant had paid to the provider and a copy of any written notice of adverse determination from a carrier, such as an explanation of benefits, indicating that reimbursement was denied due to medical necessity.
4. In accordance with 133.307(e)(3)(I), the request for medical fee dispute resolution was not submitted in compliance with the provisions of the Labor Code and this chapter; therefore, no further action will be taken.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Section. 413.011(a-d), Section. 413.031 and Section 413.0311
28 Texas Administrative Code Section. 134.1, 134.504, 133.307
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor has submitted the dispute prematurely and no further action will be taken.

DECISION:

Authorized Signature

Auditor III
Medical Fee Dispute Resolution

August 21, 2009

Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.